

**U.S. Department of Labor**

Office of Administrative Law Judges  
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**Issue Date: 30 October 2006**

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In the Matter of

O. K.<sup>1</sup>

Claimant

Case No.: 2004 BLA 6705

v.

JEWELL RIDGE MINING CORP./

SEA "B" MINING CO.

Employer

and

DIRECTOR, OFFICE OF WORKERS'

COMPENSATION PROGRAMS

Party in Interest

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Appearances: Mr. Joseph E. Wolfe, Attorney  
For the Claimant

Mr. Timothy W. Gresham, Attorney  
For the Employer/Insurer

Before: Richard T. Stansell-Gamm  
Administrative Law Judge

**DECISION AND ORDER –  
AWARD OF BENEFITS**

This matter involves a claim filed by Mr. O. K. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

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<sup>1</sup>Despite 20 C.F.R. § 725.477(b) ("A decision and order shall contain . . . the names of the parties . . ."), and over my specific objection, Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

## **Procedural History**

### First Claim (DX 1)<sup>2</sup>

On June 21, 1979, Mr. K. filed his first claim for black lung disability benefits under the Act. The District Director denied the claim on December 29, 1980 for failure to prove total disability. Through counsel, Mr. K. appealed the adverse decision on January 23, 1981 and October 29, 1982. On April 4, 1986, the case was forwarded to the Office of Administrative Law Judges ("OALJ"). On January 25, 1988, Administrative Law Judge Nicholas Laezza conducted a hearing. On December 21, 1988, Judge Laezza denied Mr. K.'s claim. Based on the preponderance of the most recent chest x-rays, which established the presence of pneumoconiosis, Mr. K. was able to invoke the interim presumption that he was totally disabled due to coal workers' pneumoconiosis under 20 C.F.R. § 727.203(a)(1). However, the preponderance medical evidence indicated Mr. K. was not totally disabled, thereby rebutting the presumption under 20 C.F.R. § 727.203(b)(2). Additionally, the record was insufficient to establish entitlement under Part 410.

### Second Claim (DX 2)

On October 2, 1997, Mr. K. submitted another application for benefits. On January 9, 1998, the District Director denied Mr. K.'s claim because he was not totally disabled. Mr. K. appealed on February 3, 1998. On June 2, 1998, the District Director again denied the claim. Mr. K. also again appealed on June 15, 1998. However, on August 13, 1998, Mr. K. withdrew his appeal.<sup>3</sup>

### Third, and Present Claim

On March 24, 2003, Mr. K. filed his third claim for black lung disability benefits (DX 4). On May 12, 2004, based on radiographic evidence of pneumoconiosis and complicated pneumoconiosis and qualifying arterial blood gas studies, the District Director awarded benefits (DX 53). On May 21, 2004, the Employer appealed (DX 55). As a result, the District Director initiated interim benefits and forwarded the case to OALJ on August 17, 2004 (DX 60 and DX 62). Following one continuance and pursuant to a Notice of Hearing, dated April 14, 2005 (ALJ I), I conducted a hearing on July 26, 2005 in Abingdon, Virginia with Mr. K., Mr. Wolfe, and Mr. Gresham.

## **Evidentiary Discussion**

At the hearing, as DX 16 and CX 1, Claimant's counsel offered Dr. Alexander's interpretation of a May 8, 2003 chest x-ray (positive for pneumoconiosis and a large opacity) as

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<sup>2</sup>The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

<sup>3</sup>For evidentiary purposes, I consider the record concerning the second claim to have closed in August 1998.

“rebuttal” under 20 C.F.R. § 725.411(a)(2)(ii). The chest x-ray had been obtained as part of the DOL-sponsored pulmonary evaluation. Previously, as part of the DOL examination, Dr. Forehand had interpreted the May 8, 2003 chest x-ray with the essentially the same principle findings (positive for pneumoconiosis and the presence of a large opacity). Although both physicians presented similar interpretations, Claimant’s counsel asserted that Dr. Alexander’s interpretation differed sufficiently from Dr. Forehand’s reading to the extent it rebutted Dr. Forehand’s findings and was thus admissible under 20 C.F.R. § 725.411(a)(2)(ii). I deferred a decision on whether to admit Dr. Alexander’s reading in the hope that the Benefit Review Board (“Board” and “BRB”) might eventually clarify whether “rebuttal” meant different or opposite.

On August 31, 2006, the Board addressed this specific issue in *Sprague v. Freeman United Coal Mining Co.*, BRB No. 05-1020 BLA (Aug. 31, 2006) (unpub.). According to the Board, “the rebuttal evidence submitted by a party pursuant to 20 C.F.R. § 725.414(a)(2)(ii), (a)(3)(ii), need not contradict the specific item of evidence to which it is responsive, but rather, need only refute ‘the case’ presented by the opposing party.” *Sprague*, 6. Accordingly, since Dr. Alexander’s positive interpretation appears to refutes the Employer’s “case,” and apparently no longer has to specifically contradict Dr. Forehand’s finding to which it responds, I now admit his interpretation of the May 8, 2003 chest x-ray, DX 16 and CX 1.<sup>4</sup>

At the hearing, I also deferred an admissibility determination concerning EX 6, Dr. Fino’s interpretation of the May 8, 2003 chest x-ray. Employer’s counsel offered Dr. Fino’s interpretation (positive for pneumoconiosis but no large pulmonary opacity present) as rebuttal to Dr. Alexander’s reading (positive for pneumoconiosis and large pulmonary opacity). Previously, the Employer offered, and I admitted, DX 17, Dr. Hippensteel’s evaluation of the May 8, 2003 film (positive for pneumoconiosis but no large pulmonary opacity) as proper rebuttal under 20 C.F.R. § 725.414(a)(3)(ii) to Dr. Forehand’s interpretation (positive for pneumoconiosis and large pulmonary opacity) of the May 8, 2003 chest x-ray, which he read as part of his DOL-sponsored pulmonary examination.

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<sup>4</sup>Although I have adjudicated this evidentiary issue in accordance with *Sprague*, the BRB’s holding is problematic for two reasons. First, in reaching its conclusion, the Board stated that the evidence being offered under the rebuttal provisions of the regulation need not contradict the specific item of evidence to which it is responsive. However, in light of the parallel structures of 20 C.F.R. § 725.414(a)(2)(i) and (ii) and 20 C.F.R. § 725.414(a)(3)(i) and (ii), the reason an item of evidence is offered “in response” to an opposing party’s evidence of the same type is indeed to contradict the opposing party’s specific item of evidence. Otherwise, the requirement for item by item responsiveness loses its meaning and no need exists for having two separate subparagraphs for case-in-chief (i) and rebuttal (ii) evidence. Second, the inclusion of the DOL examination in both rebuttal provisions, 20 C.F.R. §§ 725.414(a)(2)(ii) and (a)(3)(ii), clearly indicates that if the DOL examination is hostile to that respective party’s case, the party has the opportunity to “rebut” DOL examination findings. In other words, reading the evidentiary sections as a whole, a claimant was only provided the opportunity under 20 C.F.R. § 725.414 (a)(2)(ii) to respond to an unfavorable DOL pulmonary examination with evidence that rebutted the examination results. Now however, *Sprague* enables a claimant to use the same “rebuttal” provisions to offer additional evidence that supports an already favorable, rather than hostile, DOL examination report.

In *Ward v. Consolidation Coal Co.*, 23 BLR 1-151, 1-155 (2006), the Board held that each party may “rebut” chest x-ray “interpretations,” rather than a particular chest x-ray.<sup>5</sup> Consequently, I admit Dr. Fino’s interpretation, EX 6, as specific rebuttal to Dr. Alexander’s interpretation of the May 8, 2003 chest x-ray, DX 16 and CX 1.

In summary, in light of the above determinations and previous evidentiary rulings, my decision in this case will be based on the hearing testimony and the following documents admitted into evidence: DX 1 to DX 65, CX 1 to CX 3, and EX 1 to EX 10.

## **ISSUES**

1. Whether in filing a subsequent claim in March 2003, Mr. K. has demonstrated that a change has occurred in one of the conditions or elements of entitlement upon which the withdrawal of his appeal of the denial of his first claim was based in August 1998.
2. If Mr. K. establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

## **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

### **Stipulations of Fact**

At the hearing, the parties stipulated to the following facts: a) Mr. K. had post-1969 coal mine employment; b) the length of his coal mine employment was at least 17.33 years; and, c) Jewell Ridge Mining Corporation and its successor, Sea “B” Mining Company, is the responsible operator. (TR, pages 10 and 11).

### **Preliminary Findings**

Born on July 22, 1933, Mr. K. started mining coal in the early 1950s. Following a mine-related back injury, Mr. K. stopped mining coal in July 1980. In his last job as a coal miner, Mr. K. was a roof bolter. His work involved heavy manual labor because he had to bend the roof bolts due to the low coal and carry roof bundles weighing up to 40 pounds. Since 2001, Mr. K. has worked as a flagman for road construction. Mr. K. started smoking cigarettes regularly when he was 10 years old. At one time, he smoked up to one pack of cigarettes a day; however when he quit smoking in the 1990s,<sup>6</sup> a pack of cigarettes usually lasted two days. (DX 1, DX 4, and TR, pages 18 to 33).

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<sup>5</sup>In apparent contrast with *Sprague*, under this BRB evidentiary rule, the offered chest x-ray interpretation must be both responsive and contrary to a specific chest x-ray interpretation offered by the opposing party to be considered proper rebuttal.

<sup>6</sup>Mr. K indicated he quit smoking cigarettes in the early 1990’s. However, treatment notes from 1997 show he was still smoking and advised to stop (EX 1 and EX 3).

## **Issue #1 – Change in Applicable Condition of Entitlement**

After the expiration of one year from the denial of benefits, the submission of additional material or another claim is considered a subsequent claim and adjudicated under the provisions of 20 C.F.R. § 725.309(d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied (“applicable condition of entitlement”) has changed and is now present. 20 C.F.R. § 725.309(d)(3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309(d)(4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Co. v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

To receive black lung disability benefits under the Act, a claimant must prove four basic conditions, or elements, related to his physical condition. First, the miner must establish the presence of pneumoconiosis.<sup>7</sup> Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.<sup>8</sup> Third, the miner has to demonstrate he is totally disabled.<sup>9</sup> Fourth, the miner must prove the total disability is due to pneumoconiosis.<sup>10</sup>

Based on those four principal conditions of entitlement, the adjudication of a subsequent claim involves the identification of the condition(s) of entitlement a claimant failed to prove in the prior claim and then an evaluation of whether through newly developed evidence a claimant is able to prove that condition(s) of entitlement. Mr. K.'s most recent prior claim was denied in June 1998 due to his failure to prove total disability. Consequently, for purposes of adjudicating this subsequent claim, I will evaluate the evidence developed since the denial of the most recent prior claim to determine whether Mr. K. has become totally disabled.

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<sup>7</sup>20 C.F.R. § 718.202.

<sup>8</sup>20 C.F.R. § 718.203(a).

<sup>9</sup>20 C.F.R. § 718.204(b).

<sup>10</sup>20 C.F.R. § 718.204(a).

### Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204(b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204(b)(1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating that a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprise*, 49 F.3d 993 (3d Cir. 1995), the court stated that to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. K. has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. K. must demonstrate total respiratory or pulmonary disability through the regulatory presumption associated with complicated pneumoconiosis, arterial blood-gas tests, pulmonary function tests, or reasoned medical opinion.

### Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability and death due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921(c)(3)(A) and (C), as implemented by 20 C.F.R. § 718.304(a), Congress determined that if a miner suffered from a chronic dust disease of the lung which "when diagnosed by chest X-ray, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C," there shall be an irrebuttable presumption that his death was due to pneumoconiosis.<sup>11</sup> This type of large opacity is called "complicated pneumoconiosis." The statute and regulation also permit complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence. 30 U.S.C. 921(c)(3)(B) and (C) and 20 C.F.R. §§ 718.304(b) and (c).

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<sup>11</sup>On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes, identified by letters. Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B means an opacity, or opacities "larger or more numerous than Category A" whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

According to the U.S. Court of Appeals for the Fourth Circuit in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by “congressionally defined criteria.” As a result, the statute’s definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. 921(c)(3)(A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921(c)(3)(B) and (C). *Scarbro*, 220 F.3d at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921(c)(3)(B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921(c)(3)(A).<sup>12</sup> Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community’s definition of the disease. *Scarbro*, 220 F.3d at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated,

if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id.*

Referencing a 1993 case from the Fourth Circuit, *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46 (4th Cir. 1993) the Benefit Review Board in *Mullins v. Plowboy Coal Co.*, BRB No. 04-0716 BLA, (July 8, 2005) (unpub.), emphasized that an administrative law judge “must weigh together all of the evidence relevant to the presence or absence of pneumoconiosis.” That mandate is consistent with other case law indicating that all evidence relevant to whether the miner has pneumoconiosis must be weighed. *Gray v. SLC Coal Co.*, 176 F.3d 382 (6th Cir. 1999), *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

In other words, even if the presence of large opacities is established through one of the three methods set out in § 718.304, all other medical evidence must be considered and evaluated to determine whether the large opacities actually exist and involve pneumoconiosis. For example, the Benefits Review Board affirmed a finding of complicated pneumoconiosis under 20 C.F.R. §718.304 when the administrative law judge considered chest x-rays in conjunction with CT scan results to find complicated pneumoconiosis. *Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA (Sept. 27, 1996). In another case, despite radiographic evidence of large opacities, the U.S. Court of Appeals for the Sixth Circuit upheld a determination that complicated pneumoconiosis did not exist based on probative autopsy evidence indicating the lesions were not complicated pneumoconiosis. *Gray*, 176 F.3d at 388.

In light of these statutory, regulatory and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a three step process.

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<sup>12</sup>See also 20 C.F.R. §§ 718.304(b) and (c).

First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence shows massive fibrosis; or c) other diagnostic results exist which are equivalent to the requisite chest x-ray or biopsy evidence of large opacities.

Second, if large opacities are established, I must also evaluate all the other relevant evidence in the record to determine whether it confirms or contradicts the presence of large opacities. In other words, I must assess whether the preponderance of the entire evidentiary record establishes the presence of large pulmonary opacities.

Third, if the preponderance of the evidence demonstrates the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence contradicts or supports a finding that the large opacities are indicative of complicated pneumoconiosis.

### 1. Existence of Large Opacities

In the absence of biopsy evidence, Mr. K. must rely on chest x-ray imaging, or other medical tests or means to establish the presence of large opacities.

#### *Chest X-Rays*

Date of x-ray	Exhibit	Physician	Interpretation
May 8, 2003	DX 13	Dr. Forehand, B <sup>13</sup>	Positive for pneumoconiosis, profusion 1/1, <sup>14</sup> type q/s opacities, <sup>15</sup> and large category A opacity. Rule out malignancy. Irregular densities in right upper and left middle zones.

<sup>13</sup>The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202(a)(1)(ii).

<sup>14</sup>The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102(b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

<sup>15</sup>There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, *RESPIRATORY DISEASES* 581 (3d ed. 1981). According to the ILO Form instructions, for a mixed group of shapes and sizes of opacities, the predominant shape and size is recorded first and the “presence of a significant number of another shape and size is recorded after the oblique stroke.”



(same)	DX 16 & CX 1	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/2, type p/t opacities. Large, 12 mm, category A opacity, complicated pneumoconiosis present in right upper zone.
(same)	EX 6	Dr. Fino, B	(Positive for pneumoconiosis), <sup>16</sup> profusion category 1/2, type u/p opacities. No large opacity noted.
(same)	DX 17	Dr. Hippensteel, B	(Positive for pneumoconiosis), profusion category 1/1, type s/q opacities. A questionable 2 cm large opacity is present in right upper lobe.
December 8, 2003	DX 17	Dr. Hippensteel, B	(Positive for pneumoconiosis), profusion category 2/2, type s/q opacities. A questionable 2 cm large opacity is present in right upper lobe.
March 16, 2005	CX 3	Dr. Rasmussen, B	Positive for pneumoconiosis, profusion category 1/2, type t opacities. Category A large opacity present.
(same)	EX 5	Dr. Fino, B	(Positive for pneumoconiosis), profusion category 1/2, type u/q opacities. No large opacity noted.
April 7, 2005	CX 2	Dr. DePonte, BCR, B	(Positive for pneumoconiosis), profusion category 2/2, type t/q opacities. Category A large opacity present. Pattern atypical for pneumoconiosis. CT scan recommended.
(same)	EX 4	Dr. Fino, B	(Positive for pneumoconiosis), profusion category 1/2, type u/q opacities. No large opacity noted. <sup>17</sup>

Of the four chest x-rays in this claim's record, there is no dispute concerning the December 8, 2003 film in which Dr. Hippensteel observed a 2 cm large opacity. Therefore, the December 8, 2003 chest film establishes the presence of a large opacity, greater than 1 cm.

In the May 8, 2003 chest x-ray, Dr. Alexander, a dual qualified radiologist, noted the presence of Category A large pulmonary opacity. Two additional B readers, Dr. Forehand and Dr. Hippensteel also observed large pulmonary opacities ranging from 1.2 to 2 cm. On the other hand, Dr. Fino, also a B reader, did not annotate the presence of a large pulmonary opacity. On this radiographic study, the preponderance of interpretations finding a large pulmonary opacity, which includes the most probative reading by a dual qualified radiologist, outweighs Dr. Fino's negative finding. Accordingly, the May 8, 2003 chest x-ray contains a large pulmonary opacity.

The March 16, 2005 chest x-ray produced an even split of opinion. Dr. Rasmussen, a B reader, observed a Category A large pulmonary opacity; Dr. Fino apparently did not. As B readers, both physicians have the same qualifications to interpret this film. As a result, their professional dispute renders the March 16, 2005 chest x-ray inconclusive for the presence of a large pulmonary opacity.

<sup>16</sup>In *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (Oct. 29, 1999) (en banc on recon.), the BRB stated that a physician's actual chest x-ray annotations and interpretation on the ILO form controls over the additional comments provided by the doctor. Consequently, according to the BRB, if a physician's chest x-ray interpretation represents pneumoconiosis under the regulation but the doctor then provides an additional opinion indicating the opacities do not constitute pneumoconiosis, the later observation is relevant to the source of the pneumoconiosis rather than the presence of pneumoconiosis. I have placed such interpretations in parentheses.

<sup>17</sup>Notably, Dr. Fino also stated there "may be" coalescence of nodular lesions in the right upper zone; however, the view was obscured by the clavicle and ribs.

The April 7, 2005 chest x-ray also produced a split of opinion. Dr. DePonte, a dual qualified radiologist, reported the presence of a Category A large opacity. Once again, Dr. Fino did not report any large pulmonary opacity. Due to Dr. DePonte's superior qualifications,<sup>18</sup> I give her interpretation greater probative value. Consequently, Dr. DePonte's more probative reading outweighs Dr. Fino's contrary opinion and establishes that the April 7, 2005 chest x-ray contains a large pulmonary opacity.

In summary, setting aside the inconclusive March 16, 2005 film, the remaining three radiographic studies from May 8, 2003, December 8, 2003, and April 7, 2005 establish the presence of a large pulmonary opacity in Mr. K.'s chest. Consequently, Mr. K. has established the presence of a large opacity in his lungs through chest x-rays which is a requirement of 20 C.F.R. § 718.304(a) for the invocation of the irrebuttable presumption of total disability due to pneumoconiosis.

## 2. Other Evidence of Large Opacities

Although the preponderance of chest x-rays establishes the presence of a large pulmonary opacity, I must assess the other relevant evidence to determine whether it confirms or negates the radiographic finding of a large pulmonary opacity. In Mr. K.'s case, that potentially relevant evidence consists of two interpretations of a December 8, 2003 CT scan.<sup>19</sup>

In reviewing this intensified radiographic study, Dr. Hippensteel, a B reader, noted the presence of nodules in both upper lobes that measured "up to 2 cm in diameter" (DX 17). This CT scan interpretation clearly reinforces the chest x-ray evidence and confirms the presence of large pulmonary opacities in Mr. K.'s lungs.

However, according to Dr. Fino, also a B reader, the CT scan was negative for either simple or complicated pneumoconiosis (EX 4). In his subsequent discussion about the CT scan, Dr. Fino did not further address whether the possible coalescence of nodules he observed on the April 7, 2005 chest x-ray was present in the CT scan (EX 9). Instead, Dr. Fino focused his discussion on how the CT scan findings supported a diagnosis of sarcoidosis.

At first glance, Dr. Fino's CT scan comments might seem to offset Dr. Hippensteel's finding of large pulmonary nodules. However, due to a lack of precision and collateral comments about his chest x-ray interpretation, I less confidence in his assessment and give his terse finding diminished probative value in regards to whether the CT scan contained images of large pulmonary opacities. Dr. Fino simply states the CT study was negative for complicated

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<sup>18</sup>See *Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist in comparison to a physician who is only a B reader).

<sup>19</sup>Both Dr. Hippensteel and Dr. Fino explained that the CT scan process involves high resolution scanning of the lungs to produce multiple images which are more sensitive and specific than chest x-rays in identifying lung disease. Based on their comments, I find the December 8, 2003 CT scan is medically acceptable and relevant to the determination of Mr. K.'s entitlement to benefits. See *Tapley v. Bethenergy Mines, Inc.*, BRB No. 04-0790 BLA (May 26, 2005) (unpub.).

pneumoconiosis. Notably absent in his discussion about the CT scan is any comment on whether he observed a large opacity. Based on his comments about his chest x-ray interpretation, that silence can have two meanings. In interpreting the chest x-ray, he acknowledged a possible coalescence of nodules in the right upper lung zone. However, Dr. Fino later stated that he did not annotate the presence of a large pulmonary opacity on the chest x-ray ILO form because he didn't see a solid opacity consistent with complicated pneumoconiosis. Based on that statement, Dr. Fino's negative CT scan finding could mean either: a) no large pulmonary nodules were contained in the CT study; or, b) large pulmonary nodules were present but not indicative of, or consistent with, complicated pneumoconiosis.

In light of the diminished "negative" finding by Dr. Fino, I find that the December 8, 2003 CT scan, as interpreted by Dr. Hippensteel, establishes the presence of large pulmonary nodules and corroborates the preponderance of the chest x-rays which also shows the presence of a large pulmonary opacity. As a result, Mr. K. has definitively established the presence of a large pulmonary opacity which exceeds 1 cm in chest x-rays.

### 3. Cause, or Etiology, of Large Opacities

Through radiographic evidence, as supported by the December 8, 2003 CT scan, Mr. K. has proven the existence of a large pulmonary opacity. As a result, I move to the third adjudicative step and consider other relevant medical evidence on the cause of the opacities prior to making a determination of whether Mr. K. can invoke the 20 C.F.R. § 718.304 irrebuttable presumption for complicated pneumoconiosis. At this point, I consider all other medical evidence to determine whether the large pulmonary opacity is due to coal mine dust exposure or coal workers' pneumoconiosis. In Mr. K.'s case, this "other" medical evidence has four components: a) other objective medical test results; b) additional comments by physicians who evaluated his chest x-rays; c) additional CT scan comments; and, d) medical opinion.

#### *Objective Medical Test Results*

##### Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV <sup>1</sup> pre <sup>20</sup> post <sup>21</sup>	FVC pre post	MVV pre post	% FEV <sup>1</sup> / FVC pre post	Qualified <sup>22</sup> pre Post	Comments
DX 12	June 16, 1998	64	2.26	3.31	---	68%	No <sup>23</sup>	Mild

<sup>20</sup>Test result before administration of a bronchodilator.

<sup>21</sup>Test result following administration of a bronchodilator.

<sup>22</sup>Under 20 C.F.R. § 718.204(b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

<sup>23</sup>The qualifying FEV1 number is 1.90 for age 64 and 69"; the corresponding qualifying FVC and MVV values are 2.45 and 75, respectively.

	Dr. Snow	69"						obstruction
DX 12	July 2, 2001 Dr. Bradfore	67 69"	2.69	4.12	---	65%	No <sup>24</sup>	Small airways disease.
DX 13	May 8, 2003 Dr. Forehand	69 67"	2.57	4.25	65	60%	No <sup>25</sup>	Normal
DX 17	Dec. 8, 2003 Dr. Hippensteel	70 69"	2.52 2.36	4.18 4.05	72	60% 58%	No <sup>26</sup> No	
CX 3	Mar. 16, 2005 Dr. Rasmussen	71 68"	2.62 2.70	4.79 4.73	---	55% 57%	No <sup>27</sup> No	Slight obstruction
EX 4	Apr. 7, 2005 Dr. Fino	71 68"	2.34 2.37	4.16 4.07	---	56% 58%	No No	Normal

### Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO <sup>2</sup> (rest) pCO <sup>2</sup> (exercise)	pO <sup>2</sup> (rest) pO <sup>2</sup> (exercise)	Qualified <sup>28</sup>	Comments
DX 13	May 8, 2003 Dr. Forehand	36 33	63 53	Yes <sup>29</sup> Yes <sup>30</sup>	Hypoxemia with exercise.
DX 17	Dec. 8, 2003 Dr. Hippensteel	39.2 37	66.9 52.9	No <sup>31</sup> Yes <sup>32</sup>	Hypoxemia with exercise.
CX 3	Mar. 16, 2005 Dr. Rasmussen	39 35	77 55	No Yes <sup>33</sup>	Hypoxemia with exercise.
EX 4	Apr. 7, 2005 Dr. Fino	41.2 40.3	76.5 78.9	No <sup>34</sup> No	(Exercise test invalid)

<sup>24</sup>The qualifying FEV1 number is 1.85 for age 67 and 69"; the corresponding qualifying FVC and MVV values are 2.38 and 74, respectively.

<sup>25</sup>The qualifying FEV1 number is 1.66 for age 69 and 67"; the corresponding qualifying FVC and MVV values are 2.15 and 67, respectively.

<sup>26</sup>The qualifying FEV1 number is 1.80 for age 70 and 69"; the corresponding qualifying FVC and MVV values are 2.33 and 72, respectively.

<sup>27</sup>The qualifying FEV1 number is 1.69 for age 71 and 68"; the corresponding qualifying FVC and MVV values are 2.20 and 68, respectively.

<sup>28</sup>To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO<sup>2</sup> level, the value of the coal miner's pO<sup>2</sup> must be equal to or less than corresponding pO<sup>2</sup> value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

<sup>29</sup>For the pCO<sup>2</sup> of 36, the qualifying pO<sup>2</sup> is 64 or less.

<sup>30</sup>For the pCO<sup>2</sup> of 33, the qualifying pO<sup>2</sup> is 67 or less.

<sup>31</sup>For the pCO<sup>2</sup> of 39, the qualifying pO<sup>2</sup> is 61 or less.

<sup>32</sup>For the pCO<sup>2</sup> of 37, the qualifying pO<sup>2</sup> is 63 or less.

<sup>33</sup>For the pCO<sup>2</sup> of 35, the qualifying pO<sup>2</sup> is 65 or less.

<sup>34</sup>For the pCO<sup>2</sup> of 40 to 49, the qualifying pO<sup>2</sup> is 60 or less.

## Other Blood Tests

As part of his December 8, 2003 pulmonary examination (DX 17), Dr. Hippensteel had Mr. K.'s blood evaluated for the presence of two granulomatous diseases: histoplasmosis<sup>35</sup> and sarcoidosis.<sup>36</sup> Mr. K.'s test for histoplasmosis was negative; whereas, it is usually positive in 50 to 80% of the people who have histoplasmosis. The angiotensin converting enzyme test was in the normal range, "which is sometimes elevated if sarcoidosis is present as a granulomatous disease."

## Discussion

The recent pulmonary tests demonstrate Mr. K. has a significant totally disabling respiratory impairment in terms of insufficient blood oxygenation upon exercise. At the same time, Mr. K.'s non-qualifying pulmonary function tests and qualifying arterial blood gas studies do not specifically isolate the cause of his respiratory impairment or provide sufficient evidence standing alone to determine the pathology associated with the large opacity in his lungs.

The two other laboratory tests conducted by Dr. Hippensteel provide information that may reduce the likelihood that the large pulmonary opacity is related to histoplasmosis or sarcoidosis. However, understandably, the tests also do not identify pneumoconiosis as a cause of the large pulmonary opacities.

## *Additional X-Ray Comments*

Although Dr. DePonte reported profusion and opacities consistent with pneumoconiosis, and a Category A large pulmonary opacity in her interpretation of the April 7, 2005 chest x-ray, she also indicated that the "pattern is atypical for coal workers' pneumoconiosis." As a result, Dr. DePonte recommended a CT scan for a definitive diagnosis.

Likewise, after interpreting the May 8, 2003 chest x-ray as positive for pneumoconiosis and a large pulmonary opacity, Dr. Forehand recommended a CT scan to rule out a malignancy. He also noted the presence of irregular opacities.

Based on the rounded shape of some of the opacities in the chest x-rays, Dr. Hippensteel could not exclude the presence of pneumoconiosis. However, the physician believed the pattern of opacities was more consistent with granulomatous disease.

In the April 7, 2005 chest x-ray, Dr. Fino noted the primary opacities were irregular and inconsistent with pneumoconiosis. He also stated there "may be" coalescence of nodular lesions in the right upper zone; however, the view was obscured by the clavicle and ribs.

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<sup>35</sup>An infection resulting from inhalation of fungi spores found in the soil. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 770 (28th ed. 1994).

<sup>36</sup>A granulomatous reticulosis of unknown origin. *Id.* at 1484.

## Discussion

When Dr. Hippensteel and Dr. Fino evaluated the recommended CT scan, taken in December 2003, neither physician found a malignancy. Consequently, the December 2003 CT scan seems to address the concerns of Dr. Forehand and Dr. DePonte about the possible malignant nature of the large pulmonary opacity. On the other hand, as further discussed below, the December 2003 CT scan did not provide a definitive diagnosis of pneumoconiosis. Consequently, the comments by Dr. Forehand, Dr. DePonte, Dr. Hippensteel, and Dr. Fino about the pattern of opacities being irregular and “atypical” for pneumoconiosis provides some evidence that the large opacity may not be related to pneumoconiosis.

### *December 8, 2003 CT Scan Comments*

Although he noted the presence of round opacities in both upper lobes, Dr. Hippensteel indicated that the 2 cm nodules in both upper lobes were “associated with adenopathy<sup>37</sup> in both hilar<sup>38</sup> areas up to 3 cm with no significant calcifications seen” (DX 17). Additionally, the CT scan did not show any “capturing” of the smaller nodules into the large nodules. Based on these observations, Dr. Hippensteel opined that the CT scan “makes granulomatous disease the most likely diagnosis, rather than coal workers’ pneumoconiosis.”

For two reasons, Dr. Fino found the sensitive CT scan negative for the presence of pneumoconiosis. First, most of the abnormalities were in the middle lung zones rather than the upper lung zones. Second, the primary opacities were irregular, rather than rounded. When pneumoconiosis is present, it develops in the upper lung zones and causes rounded opacities. On the other hand, Dr. Fino acknowledged the presence of secondary opacities that were rounded and consistent with pneumoconiosis. Nevertheless, he found the possibility that pneumoconiosis was co-existing with his primary finding of sarcoidosis too speculative for a diagnosis.

## Discussion

I have previously determined that Dr. Fino’s analysis of the CT scan as to the presence of a large pulmonary opacity has diminished probative value. As I will discuss later, his additional comments about even the presence of pneumoconiosis also have diminished probative value. On the other hand, Dr. Hippensteel’s specific assessment of the CT scan showing the absence of a coalescence of nodules represents some credible evidence that the large pulmonary opacity is not related to pneumoconiosis.

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<sup>37</sup>Enlargement. *Id.* at 28.

<sup>38</sup>*Id.* at 767.

*Medical Opinion*

Dr. J. Randolph Forehand  
(DX 13)

On May 8, 2003, Dr. Forehand, board certified in pediatrics, allergy and immunology, conducted a pulmonary evaluation. Mr. K. had over 19 years of coal mine employment; and he last worked as a roof bolter. Mr. K. smoked 1/2 pack of cigarettes per day from 1938 to 1993. He complained about shortness of breath upon exertion. His medical history included irregular heartbeat in the 1970s and a back injury in the 1980s. Upon physical examination, Dr. Forehand heard crackles in both lung bases. Mr. K.'s pulse was strong with no noted abnormalities. The EKG was borderline with normal sinus rhythm and some ventricular delay. The chest x-ray was positive for pneumoconiosis and a large pulmonary opacity. The pulmonary function test was normal. The arterial blood gas study indicated hypoxemia with exercise. Based on Mr. K.'s work history, the pulmonary examination, chest x-ray and arterial blood gas study, Dr. Forehand diagnosed coal workers' pneumoconiosis. Although he believed the cause of the pneumoconiosis was Mr. K.'s coal mine employment, Dr. Forehand recommended a CT scan to rule out a malignancy. Due to a significant respiratory impairment, Mr. K. had insufficient oxygen transfer capacity to return to coal mine employment. He was permanently and totally disabled by the pulmonary impairment.

Dr. Kirk E. Hippensteel  
(DX 17, EX 8, and EX 10)

On December 8, 2003, Dr. Hippensteel, board certified in pulmonary disease and internal medicine, evaluated Mr. K.'s pulmonary condition. The physician also reviewed the medical record, which included Dr. Forehand's May 2003 examination. Mr. K. had been a coal miner for over 19 years. He last worked as a roof bolter which involved heavy labor. During his employment, Mr. K. suffered a back injury and crushed vertebra. Starting when he was 5 years old, Mr. K. smoked cigarettes until about 1993, averaging half a pack per day. Mr. K. reported no exposure to tuberculosis or bird waste. His medical history included hospitalization for borderline congestive heart failure in November 2003. Upon physical examination, Dr. Hippensteel heard mild, scattered wheezes. The electrocardiogram ("EKG") was borderline abnormal. The chest x-ray showed opacities that could be classified as pneumoconiosis, with large opacities of about 2 cm in the right upper lobe. Within the large lesions were rounded calcifications as well as rounded calcified granulomas. A CT scan indicated no distinct capturing of the smaller pulmonary nodules into the larger nodules. In Dr. Hippensteel's opinion, even though the radiographic changes did "not exclude coal workers' pneumoconiosis as a diagnosis, the changes found on the chest x-ray are most compatible with granulomatous disease." The pulmonary function study was normal. Although the resting arterial blood gas study was also normal, with exercise Mr. K. became hypoxic. The tests for histoplasmosis and sarcoidosis were normal or negative.

In identifying the cause of Mr. K.'s respiratory impairment, Dr. Hippensteel stressed several points. First, although the exercise arterial blood gas study showed hypoxemia, Mr. K.'s pulmonary function test demonstrated that his diffusion was not significantly impaired. As a

result, Dr. Hippensteel believed Mr. K.'s breathing problems were "cardio related rather than pulmonary related." Mr. K.'s cardiac condition was caused by his hypertension and significant cigarette smoking history. Second, the large pulmonary opacities had calcifications, which is typical for granulomatous disease rather than coal workers' pneumoconiosis. Consequently, although the laboratory tests did not identify a specific granulomatous disease, the overall medical evidence led to a conclusion that a granulomatous disease is the cause of the chest x-ray abnormalities. Third, although Dr. Hippensteel could not exclude coal workers' pneumoconiosis as a diagnosis, he believed the large opacities are secondary to granulomatous disease, rather than pneumoconiosis; "or, at most, [Mr. K.] has a minor component of coal workers' pneumoconiosis mixed in with granulomatous disease." If the large opacities were complicated coal workers' pneumoconiosis, Dr. Hippensteel would expect to also find progressive massive fibrosis. However, Mr. K. did not have progressive massive fibrosis because the pulmonary function tests disclosed only a mild airflow obstruction, no restriction, and normal diffusion. When granulomatous disease causes large opacities, it does not develop into progressive massive fibrosis.

In a July 18, 2005 deposition, Dr. Hippensteel reviewed Mr. K.'s social and work histories and the results of his pulmonary evaluations in 1998 and 2003. The more recent pulmonary function test showed a minimal obstructive impairment that was not clinically significant. The resting arterial blood gas study was normal. However, the exercise arterial blood gas test showed an oxygenation impairment most likely due to a cardiac problem since the pulmonary function test did not show a significant reduction in diffusion. Most of the more recent exercise arterial blood gas studies produced similar results and demonstrate a worsening of Mr. K.'s oxygen exchange impairment. At the same time, Dr. Hippensteel stressed that an arterial blood gas study is not diagnostic of any specific disease since an abnormality may be due to a heart problem or a variety of lung conditions. The physician also noted that the negative sarcoidosis test did not preclude that disease as a possible diagnosis. Since some of the pulmonary opacities in the radiographic film were non-calcified, Dr. Hippensteel could not "exclude" coal workers' pneumoconiosis; however, the pattern of the opacities was "a lot more suggestive of granulomatous disease." Dr. Hippensteel also noted that a subsequent chest x-ray had a lower profusion whereas a change in profusion is not "typical" for pneumoconiosis.

Turning to the CT scan, Dr. Hippensteel stressed that the study was more sensitive than a chest x-ray for "picking up" interstitial lung disease and removing the obscuring bone structures that block x-ray images. In Mr. K.'s CT scan, Dr. Hippensteel observed "opacities mainly in the posterior upper lobes which extended to the pleura in the right upper lobe which is not typical for large opacities from coal workers' pneumoconiosis." Also absent was a coalescence of small nodules into large opacities that if present "would more likely to be from coal workers' pneumoconiosis."

Having reviewed Dr. Fino's evaluation, Dr. Hippensteel was aware of his diagnosis of sarcoidosis, which is a granulomatous disease that causes abnormalities consistent with Mr. K.'s chest x-rays and CT scan. Although the test for sarcoidosis was normal, that disease is not ruled out because:



There is a high percentage of sarcoidosis patients who have normal levels. If it had been elevated, I think it would have been in effect, in this case, the clincher as the most proof positive that that was the type of granulomatous disease it is. I think we have evidence that this is [an] abnormalit[y] related to granulomatous disease and I think sarcoidosis is probably the main prospect for it, but at the same time it can be some other granulomatous disease too and that is one reason I checked about histoplasma titer since he had risk factors for that too.

Dr. Hippensteel also noted that Mr. K.'s gas exchange abnormalities were variable, which is "not consistent with coal workers' pneumoconiosis causing a fixed impairment in gas exchange." Instead, the variability was related to his "heart function." Additionally, Mr. K.'s back injury contributed to his breathing difficulties. As a result, Dr. Hippensteel concluded Mr. K. did not have an impairment that was related to his pulmonary condition. Dr. Hippensteel based his conclusions on his examination and Mr. K.'s history of congestive heart failure. While acknowledging that Mr. K.'s heart rhythm was regular with only a mild systolic murmur and the EKG indicated only mild ischemic changes, Dr. Hippensteel stated those clinical findings nevertheless showed the cardiac problems were the cause of the marked blood gas changes.

Finally, Dr. Hippensteel confirmed that Mr. K. had a large opacity or density in the right upper lobe and the objective medical evidence did not exclude black lung as a diagnosis.

Dr. D. L. Rasmussen  
(CX 3)

On March 16, 2005, Dr. Rasmussen, board certified in internal medicine, examined Mr. K., who was a coal miner for over 19 years. In his last job as a coal miner, Mr. K. engaged in heavy to very heavy manual labor as a roof bolter. In 1988, he suffered a back injury. He started regularly smoking cigarettes at the age of 10. Before quitting in 1992, Mr. K. smoked between 1/2 to 1 pack of cigarettes a day. His medical history included cardiac catheterization for three blocked arteries in 2004 and long term hypertension. The physical examination revealed moderately reduced breath sounds. Although the heart tones were reduced, the heart beat was regular and the EKG was normal. The chest x-ray was positive for both coal workers' pneumoconiosis and complicated pneumoconiosis with bilateral Category A large pulmonary opacities. The pulmonary function tests indicated a slightly reversible pulmonary obstruction. While the resting arterial blood gas study was normal, the exercise test showed a marked impairment in oxygen transfer to the extent Mr. K. was totally disabled. Based on his employment history and the chest x-ray, Dr. Rasmussen diagnosed complicated pneumoconiosis, Category A, due to coal mine employment. Additionally, the causes of Mr. K.'s pulmonary impairment are cigarette smoke and coal mine dust. Both pulmonary risk factors cause lung tissue damage, including chronic bronchitis, emphysema, and small airways disease. Coal mine dust exposure can also adversely impact oxygen transfer capacity.

Dr. Gregory J. Fino  
(EX 4, EX 7, and EX 9)

On April 7, 2005, Dr. Fino, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation and reviewed the medical record which included the recent pulmonary evaluations by Dr. Forehand, Dr. Hippensteel, and Dr. Rasmussen. Mr. K. had 20 years of coal mine employment and presented with long term shortness of breath. He had smoked a 1/2 to 1 pack of cigarettes a day between 1943 and 1992. The physical examination and pulmonary function studies were normal. The heart examination was normal. The chest x-ray was abnormal and positive for the presence of simple coal workers' pneumoconiosis. The resting blood gas study was normal. When the exercise test was attempted, Mr. K. couldn't exercise properly. As a result, Dr. Fino stated that he did not "believe these values are a true representation of exercise induced arterial oxygenation." However, based on the exercise arterial blood gas studies conducted in 2003 and 2005, Dr. Fino opined that Mr. K. had "an oxygen transfer abnormality." In Dr. Fino's opinion:

all of the changes represent a granulomatous infection resulting in an oxygen transfer impairment. I believe we are dealing with the disease of sarcoidosis. This is because the primary abnormality is irregular. I really do not believe a coal mine dust related pulmonary condition is present in this case.

In a July 6, 2005 deposition, Dr. Fino indicated that in his most recent examination of Mr. K. and the other evaluations by Dr. Hippensteel and Dr. Rasmussen, the pulmonary function tests revealed a "very mild" pulmonary obstruction and normal lung volumes. However, by 2005, the diffusion values fell by 20% compared to 2003. Based on the exercise arterial blood gas studies by Dr. Hippensteel and Dr. Rasmussen, Dr. Fino believed Mr. K. had a disabling oxygen transfer abnormality which precluded his return to coal mining. This problem arose after 1997 when Mr. K.'s exercise tests did not indicate a transfer problem. The blood gas studies were not diagnostic for a specific disease. However, "they suggest a general type of interstitial disease." At the same time, the drop in oxygen transfer capacity may occur with an obstructive impairment and occasionally in other diseases which are not intrinsic lung diseases.

In the chest x-ray, Dr. Fino determined the primary opacities were irregular. Additionally, there "may have been" some coalescence of nodular lesions in the right upper lung zone. However, Dr. Fino did not mark the presence of a large opacity on the ILO form because he did not see a solid opacity consistent with complicated pneumoconiosis. Although he indicated on the ILO form that the pattern of opacities was consistent with pneumoconiosis, he believed the radiographic finding was "more consistent with a granulomatous infection, such as sarcoidosis."

For five reasons, Dr. Fino diagnosed sarcoidosis as Mr. K.'s pulmonary problem and opined that he did not have coal workers' pneumoconiosis or any lung impairment associated with his coal mine employment. First, the primary opacities were irregular which is "very unusual if not unheard of in coal workers' pneumoconiosis." With pneumoconiosis, the primary opacities are rounded. Second, as also noted by both Dr. DePonte and Dr. Forehand, the pattern of the opacities was inconsistent with pneumoconiosis. Dr. Fino observed more abnormalities on

the left side than that the right side. When pneumoconiosis is present, the abnormalities are expected to be symmetrical. Third, in the CT scan, the abnormalities were located in the middle lung zone and irregular. Pneumoconiosis produces rounded opacities in the upper lung zones. Fourth, although pneumoconiosis can be progressive, Mr. K.'s pulmonary problems started to progress long after he left coal mining. That late development, coupled with the chest x-ray and CT scan evidence points to "some other kind of condition and my first diagnosis in this case would be sarcoidosis." Fifth, Dr. Hippensteel's sedimentation test showed an elevated rate indicative of an on-going inflammatory process in Mr. K.'s body. Sarcoidosis will cause an elevation in the sedimentation rate. Further, though Mr. K.'s sarcoidosis test was normal, 50% of the patients with sarcoidosis also experience a negative test.

Dr. Fino found that Mr. K. had a respiratory impairment consisting of a disabling oxygen transfer deficiency. His totally disabling impairment was attributable to sarcoidosis and not pneumoconiosis.

Finally, Dr. Fino acknowledged that Mr. K.'s recent reduction in diffusion capacity was consistent with pneumoconiosis. He also agreed that rounded opacities consistent with pneumoconiosis were present in the radiographic studies. However, if Mr. K.'s pulmonary condition involved pneumoconiosis, Dr. Fino would expect to see the rounded opacities as the primary, rather than secondary, opacities. While it is possible for a person to have pneumoconiosis along with some other disease causing irregular opacities, that case moves "to the type of situation that I think really brings in speculation . . . in this case, I couldn't say with reasonable certainty that was what was going on."

### Discussion

Of the four physicians to evaluate Mr. K.'s pulmonary condition, only Dr. Rasmussen definitely diagnosed complicated pneumoconiosis, directly linking Mr. K.'s large pulmonary opacity to coal mine employment. Within the confines of his examination, his assessment is reasoned. However, his conclusion suffers a loss of probative value on the issue of complicated pneumoconiosis because he did not consider the more sensitive and specific December 2003 CT scan.

Notably, after finding the presence of a large Category A pulmonary opacity in the chest x-ray, Dr. Forehand did not specifically diagnose complicated pneumoconiosis. Instead, introducing some degree of uncertainty, Dr. Forehand recommended a CT scan to rule out a malignancy. Since Dr. Forehand never learned the results of the subsequent CT scan, his classification of the large pulmonary opacity as a Category A opacity consistent with complicated pneumoconiosis remains uncertain.

Dr. Fino relied heavily on the CT scan to reach his conclusion that the primary pulmonary opacities were not related to Mr. K.'s coal mine employment. However, as previously discussed, Dr. Fino did not specifically address whether the CT scan contained any large pulmonary opacities. Thus, his opinion has diminished probative value on whether the large pulmonary opacities established by the chest x-ray were related to pneumoconiosis.

Finally, also relying significantly on the more sensitive CT scan, Dr. Hippensteel identified three reasonable bases for concluding the large pulmonary opacity was not related to pneumoconiosis. First, the pattern of the large opacities was inconsistent with pneumoconiosis. Second, a coalescence of small nodules into large opacities indicative of complicated pneumoconiosis was not present. Third, Dr. Hippensteel did not observe the presence of progressive massive fibrosis which would be present if the large opacities were complicated pneumoconiosis. Absent any viable alternative interpretation of the December 2003 CT scan, Dr. Hippensteel's evaluation of that specialized series of radiographic images provides probative evidence that the larger pulmonary opacities are not related to pneumoconiosis.

### *Conclusion*

Upon consideration of the other medical evidence, I find Mr. K. has failed to prove that the larger pulmonary opacities in his chest x-rays involve pneumoconiosis. Four physicians who interpreted the chest x-rays either commented about the atypical pattern of the noted opacities or expressed the necessity to conduct a CT scan to more specifically identify the nature of the large pulmonary opacity. When the large opacity was evaluated by a CT scan, Dr. Hippensteel concluded the opacity was not related to pneumoconiosis. The sole physician to specifically diagnose complicated pneumoconiosis, Dr. Rasmussen, did not consider the CT scan, which is a better diagnostic tool. As a result, his conclusion that the large opacity in the chest x-ray was complicated pneumoconiosis does not outweigh Dr. Hippensteel's contrary conclusion based on the chest x-ray and CT scan. Consequently, since Dr. Hippensteel's probative CT scan interpretation severs the link between the large pulmonary opacity and pneumoconiosis, Mr. K. is not able to invoke the irrebuttable presumption of total disability under 20 C.F.R. § 718.304.

### *Arterial Blood Gas Studies*

Although Mr. K has not been able to establish total disability through the presence of complicated pneumoconiosis, he may still demonstrate that he has become totally disabled based on arterial blood gas studies under 20 C.F.R. § 718.204(b)(2)(ii).

Determination of total disability based on arterial blood gas studies involves five steps. First, an administrative law judge must determine whether the tests conform to the arterial blood gas study procedural requirements in 20 C.F.R. § 718.105. Second, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. Third, the results are compared to the qualifying values for the various tests listed in Appendix C to determine whether the test reaches the total disability thresholds. Fourth, a determination must be made whether the preponderance of the conforming, valid, and qualifying arterial blood gas studies supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is then made to see if it outweighs the blood gas study evidence that supports a finding of total respiratory disability. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987).

With these principles in mind, I first note that in Mr. K.'s case, the arterial blood gas studies from May 2003 through April 2005 appear to be conforming. Next, based on Mr. K.'s inability to exercise properly, Dr. Fino invalidated the April 7, 2005 exercise test. As previously summarized, the preponderance of the remaining valid, conforming arterial blood gas studies, and in particular all three valid exercise tests, met the regulatory total disability thresholds. Upon consideration of the remaining evidence, I note that Dr. Forehand, Dr. Rasmussen, and Dr. Fino concluded Mr. K. was totally disabled due to insufficient arterial blood oxygenation. Though seemingly disagreeing by concluding Mr. K. did not have a respiratory impairment, Dr. Hippensteel did not really challenge the results of the exercise blood gas tests. Instead, he reached his conclusion on the basis that Mr. K.'s impairment was due to a cardiac problem and was thus not a respiratory impairment. Accordingly, in the absence of contrary probative evidence, I conclude Mr. K. has proven total disability under 20 C.F.R. § 718.204(b)(2)(ii).

Mr. K. has proven that he has a totally disabling respiratory impairment, thereby establishing that one of the conditions of entitlement that he previously failed to prove has changed and is now present. As a result, under 20 C.F.R. § 725.309, I must now examine the entire medical record to determine whether Mr. K. is entitled to black lung disability benefits.

## **Issue #2 – Entitlement to Benefits**

Again, to establish entitlement to black lung disability benefits under Act, Mr. K. must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

### Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.<sup>39</sup> The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."<sup>40</sup> The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b). As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202(a)(1)), autopsy or biopsy report (§ 718.202(a)(2)), regulatory presumption (§ 718.202(a)(3)),<sup>41</sup> and medical opinion (§ 718.202(a)(4)). Since the

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<sup>39</sup>20 C.F.R. § 718.201(a).

<sup>40</sup>20 C.F.R. § 718.201(a)(1) and (2) (emphasis added).

<sup>41</sup>If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202(a)(3), a coal miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the coal miner is totally disabled due to pneumoconiosis); 20 C.F.R. §

record does not establish the presence of complicated pneumoconiosis, and Mr. K. filed this claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. As a result, to demonstrate pneumoconiosis Mr. K. will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis. In addition, since Mr. K. last labored as a coal miner in West Virginia, under the guidance of *Compton*,<sup>42</sup> I must consider the chest x-ray evidence and medical opinion together to determine whether he can establish the presence of pneumoconiosis.

### *Chest X-Rays*

Date of x-ray	Exhibit	Physician	Interpretation
April 26, 1974	DX 1	Dr. Cunningham, BCR, A	Negative for pneumoconiosis, profusion 0/1, type p opacities.
(same)	DX 1	Dr. Warden	Negative for pneumoconiosis.
February 21, 1980	DX 1	Eryilmaz	Positive for pneumoconiosis, profusion 1/1, type p/s opacities.
(same) (read April 24, 1980)	DX 1	Paul S. Wheeler, BCR, B	Positive for pneumoconiosis, profusion 1/2, type p opacities.
(same) (read Nov. 15, 1986)	DX 1	Paul S. Wheeler, BCR, B	Negative for pneumoconiosis, profusion 0/1, type s/p opacities. Calcified granuloma present.
(same)	DX 1	Scott, BCR, B	Negative for pneumoconiosis.
(same)	DX 1	Spitz, BCR, B	Negative for pneumoconiosis, profusion 0/1, type t opacities.
(same)	DX 1	Felson, BCR, C <sup>43</sup>	Negative for pneumoconiosis, profusion 0/1, type q opacities.
February 2, 1987	DX 1	Dr. Sargent, B	Positive for pneumoconiosis, profusion 1/2, type t opacities. No large opacity present. Possibly calcified nodular lesion in right mid lung zone requires further evaluation.
February 17, 1988	DX 1	Dr. Stewart	Positive for pneumoconiosis, profusion 1/1, type p/q opacities.
November 6, 1997	DX 2	Dr. Forehand, B	Positive for pneumoconiosis, profusion 1/1, type p/s opacities. No large opacity present.
(same)	DX 2	Dr. Gaziano, B	Positive for pneumoconiosis, profusion /12, type q/s opacities.
(same)	DX 2	Dr. Hippensteel, B	(Positive for pneumoconiosis), profusion 1/1, type t/s opacities. No large opacity present. Not typical for coal workers' pneumoconiosis.
(same)	DX 2	Dr. Fino, B	Completely negative. Diffuse interstitial markings inconsistent with pneumoconiosis.

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718.305 (for claims filed before January 1, 1982, if the coal miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption of total disability due to pneumoconiosis when a survivor files a claim prior to June 30, 1982).

<sup>42</sup>See *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

<sup>43</sup>C- C Reader. A "C Reader" designates only highly regarded individuals who developed the black lung classification system for chest x-rays and represents the highest interpreter qualification.

July 15, 1998	DX 2	Dr. Hippensteel, B	(Positive for pneumoconiosis), profusion 1/1, type t/r opacities. No large opacity present. Not typical for coal workers' pneumoconiosis.
(same)	DX 2	Dr. Fino, B	Negative for coal workers' pneumoconiosis. Diffuse markings present, inconsistent with pneumoconiosis.
May 8, 2003	DX 13	Dr. Forehand, B	Positive for pneumoconiosis, profusion 1/1, type q/s opacities, and large category A opacity. Rule out malignancy. Irregular densities in right upper and left middle zones.
(same)	DX 16 & CX 1	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/2, type p/t opacities. Large, 12 mm, category A opacity, complicated pneumoconiosis present in right upper zone.
(same)	EX 6	Dr. Fino, B	(Positive for pneumoconiosis), profusion category 1/2, type u/p opacities. No large opacity noted.
(same)	DX 17	Dr. Hippensteel, B	(Positive for pneumoconiosis), profusion category 1/1, type s/q opacities. Questionable presence of large opacity. A 2 cm large opacity is present in right upper lobe.
December 8, 2003	DX 17	Dr. Hippensteel, B	(Positive for pneumoconiosis), profusion category 2/2, type s/q opacities. A questionable 2 cm large opacity is present in right upper lobe.
March 16, 2005	CX 3	Dr. Rasmussen, B	Positive for pneumoconiosis, profusion category 1/2, type t opacities. Category A large opacity present.
(same)	EX 5	Dr. Fino, B	(Positive for pneumoconiosis), profusion category 1/2, type u/q opacities. No large opacity noted.
April 7, 2005	CX 2	Dr. DePonte, BCR, B	(Positive for pneumoconiosis), profusion category 2/2, type t/q opacities. Category A large opacity present. Pattern atypical for pneumoconiosis.
(same)	EX 4	Dr. Fino, B	(Positive for pneumoconiosis), profusion category 1/2, type u/q opacities. No large opacity noted. <sup>44</sup>

No dispute exists concerning six of the ten chest x-rays. Based on the respective uncontested interpretations of opacities consistent with pneumoconiosis, the following radiographic studies are positive for pneumoconiosis: February 2, 1987, February 17, 1988, May 8, 2003, December 8, 2003, March 16, 2005, and April 7, 2005. For that same reason, the April 26, 1974 chest x-ray is negative for pneumoconiosis.

The physicians who evaluated the February 21, 1980 chest x-ray reached contrary conclusions.<sup>45</sup> Dr. Eryilmaz and Dr. Wheeler found sufficient opacities in the radiographic film to diagnose pneumoconiosis. However, Dr. Wheeler, Dr. Scott, Dr. Spitz, and Dr. Felson did not. Setting aside Dr. Wheeler's conflicting interpretations, the remaining negative interpretations by dual qualified radiologists outweighs the sole remaining positive assessment by Dr. Eryilmaz. As a result, the February 21, 1980 chest x-ray is negative for pneumoconiosis.

<sup>44</sup>Notably, Dr. Fino also stated there "may be" coalescence of nodular lesions in the right upper zone; however, the view was obscured by the clavicle and ribs.

<sup>45</sup>Interestingly, Dr. Wheeler even disagreed with himself.

In the February 17, 1988 chest x-ray, Dr. Forehand, Dr. Gaziano, and Dr. Hippensteel observed pneumoconiosis. However, Dr. Fino did not. Since these physicians are similarly well qualified, the consensus by Dr. Forehand, Dr. Gaziano, and Dr. Hippensteel establishes the February 17, 1988 chest x-ray positive for pneumoconiosis.

Finally, the July 15, 1988 chest x-ray produced an even split of opinion. Dr. Fino believed the film was negative; whereas Dr. Hippensteel found opacities consistent with pneumoconiosis. Since Dr. Fino and Dr. Hippensteel have the same qualifications for interpreting chest x-rays, their professional dispute renders the July 15, 1998 chest x-ray inconclusive for the presence of pneumoconiosis.

In summary, setting aside the inconclusive film from July 15, 1998, seven of the nine remaining radiographic studies are positive for pneumoconiosis. As a result, Mr. K. is able to prove the presence of pneumoconiosis through the preponderance of chest x-ray interpretations under 20 C.F.R. § 718.202(a)(1).

#### *Medical Opinion*

Although Mr. K. has established the presence of black lung disease through chest x-ray evidence, *Compton* requires that I consider whether the preponderance of the medical opinion also establishes this requisite element of entitlement under 20 C.F.R. § 718.202(a)(4). In Mr. K.'s case, this inquiry is also necessary in light of the additional comments provided by a few physicians concerning the pattern of the opacities.

Dr. B. D. Berry  
(DX 1)

On February 21, 1980, Dr. Berry evaluated Mr. K.'s pulmonary condition. Mr. K. had mined coal for several years and smoked up to 1 and 1/2 packs of cigarettes a day. The chest x-ray showed the presence of pneumoconiosis. The arterial blood gas study was normal. Based on the pulmonary function test, Dr. Berry concluded Mr. K. had moderate COPD (chronic obstructive pulmonary disease) which he attributed to coal mine employment.

Dr. Roy R. Raub  
(DX 1)

Between July 22, 1980 and December 13, 1983, Dr. Raub treated Mr. K. for back pain associated with two compression fractures of his spine caused by a mining accident. Upon initial admission to the hospital after the accident, Dr. Raub reported that his lungs were clear. During the early stages of treatment, Mr. K. wore a back brace. Due to the injury, Mr. K. was unable to return to coal mining.



Dr. J. Dale Sargent  
(DX 1)

On February 5, 1987, Dr. Sargent, board certified in pulmonary disease and internal medicine, examined Mr. K. After about 18 years of coal mining, Mr. K. had to stop due to a back injury. He had smoked 1 and 1/2 packs of cigarettes a day since he was 7 years old. Upon physical examination, Dr. Sargent heard slight wheezes in the lungs. The heart sounds were normal. The chest x-ray was positive for occupational pneumoconiosis. The physician also noted a “nodular density” in the right mid lung zone that required further evaluation. The pulmonary function studies showed a mild ventilatory impairment that responded to bronchodilator therapy. Though the arterial blood gas study was “abnormal,” it was not completely out of range for a heavy cigarette smoker. Dr. Sargent anticipated the blood gas would improve with exercise. In Dr. Sargent’s opinion, although Mr. K. had simple coal workers’ pneumoconiosis, he was not totally disabled. Dr. Sargent also diagnosed chronic bronchitis due to cigarette smoking.

Dr. Gregory Fino  
(DX 1, EX 4, EX 7, and EX 9)

On December 31, 1987, Dr. Fino reviewed the medical and examination record from 1974 through 1987. He noted that the preponderance of the chest x-ray interpretations were negative. Although the 1987 pulmonary function test was invalid due to suboptimal effort, the results still showed a worsening impairment. However, the developing impairment was not due to coal workers’ pneumoconiosis because black lung causes fixed lesions. Additionally, after a person leaves the coal mines, “simple coal workers’ pneumoconiosis does not progress.” Consequently, Mr. K. did not have pneumoconiosis and “at best” only had a very mild respiratory impairment.

As previously summarized, in April 2005, based on radiographic evidence including the CT scan, Dr. Fino concluded the most consistent diagnosis was sarcoidosis. Although opacities consistent with pneumoconiosis were also present, he considered an additional, secondary diagnosis of pneumoconiosis to be too speculative.

Dr. Richard S. Buddington  
(DX 1)

On January 6, 1988, Dr. Buddington conducted a pulmonary evaluation. Mr. K. had 19 years of coal mine employment and a 28 pack year<sup>46</sup> history of cigarette smoking. Upon physical examination, Dr. Buddington heard a few rhonchi and wheezes in the lungs; the heart sounds were distant. The chest x-ray was positive for pneumoconiosis. The arterial blood gas study was abnormal. Based on the examination, Dr. Buddington concluded Mr. K.’s primary pulmonary disorder was coal workers’ pneumoconiosis. He also had chronic bronchitis and emphysema. Mr. K. was capable of heavy labor for only brief periods of time with long periods of rest.

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<sup>46</sup>A pack year equals the consumption of one pack of cigarettes a day for one year.

Dr. Gregory John Endes-Bercher  
(DX 1)

On February 17, 1988, Dr. Endes-Bercher, board certified in internal medicine, evaluated Mr. K, who had mined coal for 19 years and smoked 3/4 a pack of cigarettes for 44 years. The physical examination of the lungs and heart was normal. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests indicated a mild, small airways restrictive disease. The arterial blood gas study showed mild hypoxemia which improved with exercise. Based on the examination, Dr. Endes-Bercher concluded Mr. K. had coal workers' pneumoconiosis. However, he did not have any respiratory or pulmonary impairment.

Dr. J. Randolph Forehand  
(DX 2)

On November 6, 1997, Dr. Forehand evaluated Mr. K.'s pulmonary condition. Mr. K. had spent more than 10 years as a coal mine roof bolter. Since 1947, he had smoked a half a pack of cigarettes a day. Upon physical examination, the heart and lungs were normal. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests revealed a mild pulmonary obstruction. During the arterial blood gas study, Mr. K. was hypoxemic at rest and normal with exercise. Dr. Forehand diagnosed pneumoconiosis due to Mr. K.'s exposure to coal mine dust. Since improvement occurred with exercise, the physician believed cardiopulmonary inactivity was responsible for the abnormal resting arterial blood gas study. Consequently, Mr. K. did not have a significant respiratory impairment.

Again, as previously summarized, Dr. Forehand re-evaluated Mr. K. in May 2003. Based on the totality of the examination, including a positive chest x-ray, Dr. Forehand concluded Mr. K. had coal workers' pneumoconiosis.

Dr. Kirk E. Hippensteel  
(DX 2, DX 17, EX 8, and EX 10)

On July 15, 1998, Dr. Hippensteel conducted a pulmonary evaluation. Mr. K. had 20 years of coal mine employment as a roof bolter. He smoked a half pack of cigarettes a day since he was 12. The physical examination and EKG were normal. The chest x-ray showed interstitial markings "mostly irregular in shape with classification of t/r, 1/1, which is not typical for coal workers' pneumoconiosis." He concluded the "increased interstitial markings on the chest x-ray are not typical for coal workers' pneumoconiosis and provides findings that on this film makes me unable to rule out coal workers' pneumoconiosis as a radiographic diagnosis in this man." The pulmonary function test showed a minimum obstruction and the arterial blood gas study was normal. Mr. K. had two pulmonary risk factors, coal dust and cigarette smoke. Neither caused any significant pulmonary impairment. Upon review of the medical record, Dr. Hippensteel also noted mixed opinions on whether Mr. K. had coal workers' pneumoconiosis. Even if pneumoconiosis were present, Mr. K. was not totally disabled. Additionally, the variability in arterial blood gas studies was related to Mr. K.'s chronic bronchitis and continued cigarette smoking.

As previously discussed, following a December 2003 examination which included both a chest x-ray and CT scan, Dr. Hippensteel concluded that granulomatous disease was the more “compatible” diagnosis of radiographic evidence. At the same time, due to the nature of the secondary opacities, he could not rule out pneumoconiosis.

Dr. D. L. Rasmussen  
(CX 3)

Finally, as previously noted, based on the examination results and chest x-ray, Dr. Rasmussen diagnosed both simple and complicated pneumoconiosis.

Dr. Kathleen A. DePonte  
(CX 2)

After finding the April 7, 2005 chest x-ray positive for pneumoconiosis, Dr. DePonte noted that the pattern was atypical for pneumoconiosis.

#### Discussion

Consistent with the preponderance of the chest x-ray interpretations, and without any reservations, Dr. Berry, Dr. Sargent, Dr. Buddington, Dr. Endes-Bercher, Dr. Forehand, and Dr. Rasmussen diagnosed simple coal workers’ pneumoconiosis. None of these doctors also considered the December 2003 CT scan. However, while that more specific radiographic study provided definite evidence concerning the absence of complicated pneumoconiosis, the more specific radiographic study as interpreted by Dr. Hippensteel and Dr. Fino notably did not directly impeach the chest x-ray findings in regards to the presence of simple pneumoconiosis.

In contrast, based on the irregular shape of the primary opacities (s), and considering the other objective medical evidence, Dr. Hippensteel believed the more consistent diagnosis was granulomatous disease. However, even after reviewing the CT scan, and having identified rounded (q) opacities as the secondary densities, Dr. Hippensteel also indicated that he could not exclude coal workers’ pneumoconiosis as a diagnosis and stated that “at most” pneumoconiosis was a minor component. In other words, while Dr. Hippensteel believed Mr. K.’s principal pulmonary problem was granulomatous disease, the physician acknowledged that radiographic evidence consistent with pneumoconiosis also existed.

Similarly, rather than citing the CT scan as definitive evidence on the absence of simple pneumoconiosis, Dr. Fino believed the irregular shape and distribution of the primary opacities (u) in the chest x-rays, coupled with the clinical presentation, supported his conclusion that Mr. K. had granulomatous disease. However, believing a diagnosis of co-existing pneumoconiosis to be too speculative, Dr. Fino nevertheless acknowledged the rounded (q) secondary opacities that he observed in the chest x-rays were consistent with pneumoconiosis. Thus, although less committal than Dr. Hippensteel, Dr. Fino’s statement nevertheless confirms the presence of radiographic opacities consistent with pneumoconiosis in the chest x-rays.

Dr. DePonte's comment that the pattern is inconsistent with pneumoconiosis provides some contrary evidence. However, because Dr. DePonte did not provide any further elaboration, I consider her terse statement insufficient to demonstrate that the noted opacities, which included secondary rounded (q) opacities, were not pneumoconiosis.

In summary, the medical opinion that the radiographic evidence establishes the presence of pneumoconiosis outweighs the less than certain contrary opinions of Dr. Hippensteel and Dr. Fino, and the insufficient comment by Dr. DePonte. Accordingly, I find Mr. K. is able to establish the presence of clinical pneumoconiosis through the preponderance of medical opinion under 20 C.F.R. § 718.202(a)(4), as well as through the preponderance of radiographic evidence under 20 C.F.R. § 718.202(a)(1).

#### Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of pneumoconiosis, Mr. K. must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. § 718.203(b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.

As the parties stipulated, Mr. K. had at least 17 years of coal mine employment. As a result, he is entitled to the regulatory presumption. Upon consideration of the entire record, and for reasons previously discussed above, I find insufficient evidence to rebut that causation presumption. Specifically, although Dr. Hippensteel and Dr. Fino attribute the primary opacities to granulomatous disease, unrelated to coal mine dust exposure, both physicians confirmed the presence of additional opacities that were consistent with coal workers' pneumoconiosis. Accordingly, based on the 20 C.F.R. § 718.203(b) presumption, I find Mr. K.'s pneumoconiosis is due to his coal mine employment.

#### Total Disability

Since I have determined the medical record does not establish the presence of complicated pneumoconiosis, and evidence of cor pulmonale has not been presented, Mr. K. may establish total disability through pulmonary function tests, arterial blood gas studies, or reasoned medical opinion.

### *Pulmonary Function Tests*

Exhibit	Date / Doctor	Age / Height	FEV <sup>1</sup> pre <sup>47</sup> post <sup>48</sup>	FVC pre post	MVV pre post	% FEV <sup>1</sup> / FVC pre post	Qualified <sup>49</sup> pre Post	Comments
DX 1	Feb. 21, 198 Dr. Berry	47 69"	3.27	4.97	95	66%	No	
DX 1	Feb. 2, 1987 Dr. Sargent	53 68"	2.54 2.81	3.66 3.99	52	69% 70%	No No	
DX 1	Jan. 1, 1988 Dr. Buddington	54 68"	2.25	3.17	---	71%	No	
DX 1	Feb. 17, 1988 Dr. Endes- Bercher	54 68"	3.06 3.44	3.32 3.51	133 129	92% 98%	No No	
DX 2	Nov. 6, 1997 Dr. Forehand	64 68"	2.24	3.33	51	67%	No	
DX 2	July 15, 1998 Dr. Hippensteel	64 68"	2.05 2.22	4.27 4.30	90 73	64% 75%	No No	
DX 12	June 16, 1998 Dr. Snow	64 69"	2.26	3.31	---	68%	No <sup>50</sup>	Mild obstruction
DX 12	July 2, 2001 Dr. Bradfore	67 69"	2.69	4.12	---	65%	No <sup>51</sup>	Small airways disease.
DX 13	May 8, 2003 Dr. Forehand	69 67"	2.57	4.25	65	60%	No <sup>52</sup>	Normal
DX 17	Dec. 8, 2003 Dr. Hippensteel	70 69"	2.52 2.36	4.18 4.05	72	60% 58%	No <sup>53</sup> No	
CX 3	Mar. 16, 2005 Dr. Rasmussen	71 68"	2.62 2.70	4.79 4.73	---	55% 57%	No <sup>54</sup> No	Slight obstruction

<sup>47</sup>Test result before administration of a bronchodilator.

<sup>48</sup>Test result following administration of a bronchodilator.

<sup>49</sup>Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

<sup>50</sup>The qualifying FEV1 number is 1.90 for age 64 and 69"; the corresponding qualifying FVC and MVV values are 2.45 and 75, respectively.

<sup>51</sup>The qualifying FEV1 number is 1.85 for age 67 and 69"; the corresponding qualifying FVC and MVV values are 2.38 and 74, respectively.

<sup>52</sup>The qualifying FEV1 number is 1.66 for age 69 and 67"; the corresponding qualifying FVC and MVV values are 2.15 and 67, respectively.

<sup>53</sup>The qualifying FEV1 number is 1.80 for age 70 and 69"; the corresponding qualifying FVC and MVV values are 2.33 and 72, respectively.

<sup>54</sup>The qualifying FEV1 number is 1.69 for age 71 and 68"; the corresponding qualifying FVC and MVV values are 2.20 and 68, respectively.

EX 4	Apr. 7, 2005 Dr. Fino	71 68"	2.34 2.37	4.16 4.07	---	56% 58%	No No	Normal
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None of the pulmonary function tests in the record establish total disability under the regulations.

#### Arterial Blood Gas Studies

Exhibit	Date /Doctor	pCO <sub>2</sub> (rest) pCO <sub>2</sub> (exercise)	pO <sub>2</sub> (rest) pO <sub>2</sub> (exercise)	Qualified	Comments
DX 1	Feb. 21, 1980 Dr. Berry	41.7 451	75.4 86	No No	
DX 1	July 29, 1981 Dr. Buddington	37.9	58.8	Yes	
DX 1	Feb. 2, 1987 Dr. Sargent	37	64.5	No	
DX 1	Jan. 1, 1988 R. Buddington	36	64	Yes	
DX 1	Feb. 19, 1988 Dr. Endes-Bercher	37.8 36.5	68.1 73.4	No No	
DX 2	Feb. 4, 1994 Dr. Miller	39.3	71	No	
DX 2	Nov. 6, 1997 Dr. Forehand	37 37	59 66	Yes No	
DX 2	Jul. 15, 1998 Dr. Hippensteel	38.9	73	No	
DX 13	May 8, 2003 Dr. Forehand	36 33	63 53	Yes Yes	Hypoxemia with exercise.
DX 17	Dec. 8, 2003 Dr. Hippensteel	39.2 37	66.9 52.9	No Yes	Hypoxemia with exercise.
CX 3	Mar. 16, 2005 Dr. Rasmussen	39 35	77 55	No Yes <sup>55</sup>	Hypoxemia with exercise.
EX 4	Apr. 7, 2005 Dr. Fino	41.2 40.3	76.5 78.9	No No	(Exercise test invalid)

Starting from 1980, the preponderance of the arterial blood gas studies do not reach the total disability thresholds. However, I have determined that the preponderance of the most recent blood tests does establish total disability. Given the recognized progressive and latent nature of coal workers' pneumoconiosis,<sup>56</sup> the most recent conforming and valid pulmonary tests are the more probative assessments. According to the studies from 2003 to 2005, Mr. K. has a totally disabling blood oxygenation impairment.

In considering whether sufficient contrary evidence, most of the physicians who evaluated Mr. K. before 2003 reasonably concluded that he was not totally disabled in light of the contemporaneous pulmonary studies. However, all the doctors to examine Mr. K. since 2003

<sup>55</sup>For the pCO<sub>2</sub> of 35, the qualifying pO<sub>2</sub> is 65 or less.

<sup>56</sup>See 20 C.F.R. §718.201(c).

have found him to be totally disabled. Accordingly, based on the recent, more probative arterial blood gas studies and medical opinion, Mr. K. has established that he is totally disabled due to a respiratory impairment under 20 C.F.R. §§ 718.204(b)(1) and (2).

#### Total Disability Due to Coal Workers' Pneumoconiosis

As Mr. K. has established three of the four requisite elements for entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Pursuant to 20 C.F.R. § 718.204 (c) (1), absent a favorable regulatory presumption,<sup>57</sup> the claimant must demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition; or, 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204(c)(2) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report."

With these principles in mind, I note that the assessments of Dr. Berry, Dr. Sargent, Dr. Buddington, and Dr. Endes-Bercher have little probative value on cause of Mr. K.'s present totally disabling blood oxygenation deficiency. Significantly, due to the dated nature of their assessments, these physicians were unaware that the most recent exercise arterial blood gas studies met the total disability thresholds. Additionally, neither Dr. Raub nor Dr. DePonte opined whether Mr. K. was totally disabled due to a pulmonary impairment.

Among the physicians who were aware of Mr. K.'s present respiratory impairment, Dr. Forehand and Dr. Rasmussen identified coal workers' pneumoconiosis as one of the causes. Dr. Hippensteel and Dr. Fino disagreed. Dr. Hippensteel attributed Mr. K.'s total disability to cardiac problems. Dr. Fino identified sarcoidosis as the cause of Mr. K.'s breathing problems.

Due to the conflict in the medical reports, I must evaluate the relative probative value of the conflicting evidence in terms of documentation and reasoning. As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

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<sup>57</sup>20 C.F.R. § 718.305 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption the claimant is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more of coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. § 718.306 (a presumption exists when a survivor files a claim prior to June 30, 1982).

The second factor involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Within the parameters of his pulmonary evaluation, Dr. Forehand presented a reasoned medical opinion that Mr. K. was totally disabled due to pneumoconiosis. Although he was aware of Mr. K.'s medical history of an irregular heart beat, and the examination EKG was borderline, Dr. Forehand reasonably attributed Mr. K.'s respiratory disability to coal workers' pneumoconiosis based on the physical examination, positive chest x-ray, and qualifying exercise arterial blood gas study. However, because Dr. Forehand conducted his evaluation in May 2003, his opinion suffers some loss of probative value on the basis of documentation because he was unaware of Mr. K.'s subsequent treatment for congestive heart failure and corresponding heart catheterization in November 2003. Additionally, Dr. Forehand did not review the December 2003 CT scan.

Having conducted a pulmonary evaluation and CT scan in December 2003 and reviewed the 2003 and 2005 assessments of Dr. Forehand and Dr. Fino, Dr. Hippensteel had a firm documentary foundation upon which to base his etiology conclusion. Despite the two negative/normal tests for its presence, Dr. Hippensteel believed the radiographic evidence was most consistent with a diagnosis of granulomatous disease. He also was unable to eliminate pneumoconiosis as a diagnosis. Nevertheless, Dr. Hippensteel attributed Mr. K.'s respiratory problems to his cardiac condition caused by cigarette smoking and hypertension for three reasons. Upon consideration of each stated basis for his etiology diagnosis, I find sufficient reasoning concerns which cumulatively diminish the probative value of his opinion.

First, Dr. Hippensteel emphasized Mr. K.'s history of congestive heart failure in November 2003. However, as pointed out to Dr. Hippensteel during his deposition, despite that history, his physical examination of Mr. K. revealed a regular heart rhythm and an EKG that indicated only mild changes. To that line of inquiry, Dr. Hippensteel simply responded that those clinical findings supported, rather than contradicted, his conclusion. Absent any further explanation, and in light of Dr. Rasmussen's March 2005 examination which showed a regular heart beat and normal EKG and Dr. Fino's April 2005 evaluation of the heart which produced normal results, Dr. Hippensteel's attribution of a heart condition for Mr. K.'s profound respiratory impairment on the basis of a prior history with heart congestive does not appear to be well reasoned.

Second, Dr. Hippensteel particularly emphasized that the combination of the pulmonary function tests and arterial blood gas studies pointed to a cardiac cause for Mr. K.'s impairment. Specifically, Mr. K.'s exercise arterial blood gas study showed hypoxemia while the pulmonary function tests demonstrated his diffusion capacity was not "significantly impaired." Within the confines of the 2003 pulmonary evaluation, Dr. Hippensteel's basis for that conclusion is established. However, as Dr. Fino subsequently highlighted, the pulmonary function studies in 2005 showed a 20% reduction in Mr. K.'s diffusion capacity. Although Dr. Hippensteel



reviewed Dr. Fino's 2005 pulmonary evaluation, he did not address whether his causation diagnosis remained viable after Mr. K.'s diffusion capacity became significantly impaired in 2005.

Third, Mr. K.'s varying arterial blood gas test results were indicative of a heart problem rather than pneumoconiosis, which causes a fixed impairment. Absent further explanation, that basis for Dr. Hippensteel's causation finding is not well reasoned given the specific pattern of variability in Mr. K.'s arterial blood gas tests. Dr. Hippensteel's statement makes sense if Mr. K.'s exercise arterial blood gas studies tests had dropped and then improved. However, the variability associated with Mr. K.'s exercise arterial blood gas studies between the earlier tests in the 1980s and 1990s and the more recent evaluations in 2003 and 2005 is a worsening of his blood oxygenation deficiency. Although pneumoconiosis causes a fixed impairment, which does not improve, the disease is also recognized as being progressive, which would produce diminishing respiratory function. I also note that the three most recent valid exercise arterial blood gas studies demonstrated very little variability, producing remarkably similar results.

Since Mr. K.'s case arises within the jurisdiction of the U.S. Court of Appeals for the Fourth Circuit, Dr. Fino did not believe that Mr. K. had coal workers' pneumoconiosis, and I have concluded Mr. K. has established the presence of clinical pneumoconiosis, Dr. Fino's assessment on the cause of Mr. K.'s totally disabling respiratory impairment has little probative weight. According to the court in *Scott v. Mason Coal Co.*, 289 F.3d 263 (4th Cir. 2002), absent specific and persuasive reasons, an administrative law judge can accord little probative weight to a physician's causation opinion when his pulmonary diagnosis is in direct contradiction of the administrative law judge's finding of legal or clinical pneumoconiosis.

Even absent this judicially mandated probative value determination, I would have given Dr. Fino's determination that Mr. K.'s total respiratory impairment is due to sarcoidosis diminished probative weight. Having conducted a pulmonary evaluation in 2005, interpreted the December 2003 CT scan, and reviewed the other three pulmonary evaluations from 2003 and 2005, Dr. Fino had the best documented assessment. However, his conclusion that sarcoidosis is the sole cause of Mr. K.'s respiratory impairment has two reasoning concerns that reduce the probative value of his conclusion.

First, Dr. Fino's evaluation of both the chest x-rays and CT scan involved a "zero sum" line of reasoning in which there could be only one cause of Mr. K.'s impairment. Thus, concluding the irregular shape and distribution of the primary radiographic opacities were more consistent with a granulomatous disease, Dr. Fino diagnosed sarcoidosis and eliminated pneumoconiosis as a possible pulmonary disease. However, Dr. Fino also reported rounded secondary opacities in his chest x-ray interpretations, noted a significant reduction in Mr. K.'s pulmonary diffusion capacity, and subsequently acknowledged those opacities and diffusion decrease were consistent with pneumoconiosis. As a result, sufficient evidence existed for him to determine whether pneumoconiosis might also be present along with his primary diagnosis of sarcoidosis. Dr. Fino's explanation that he was unable to reach such co-existing conclusion because it was too "speculative" is unreasonable considering his own interpretations of the radiographic evidence and the pulmonary diffusion test results that supported a finding of pneumoconiosis.

Second, though he acknowledged that pneumoconiosis is progressive, Dr. Fino further supported his conclusion that pneumoconiosis was not a pulmonary factor by noting that Mr. K.'s pulmonary problems developed long after he left coal mining. In his opinion, such "late" development apparently mitigates against a diagnosis of pneumoconiosis. That type of reasoning is contrary to the regulatory recognition that pneumoconiosis is a latent disease which "may first become detectable only after the cessation of coal mine dust exposure." 20 C.F.R. § 718.202(c).

Based on his 2005 pulmonary evaluation and aware of Mr. K.'s heart catheterization in late 2003, Dr. Rasmussen presented a documented and reasoned medical opinion that Mr. K.'s pneumoconiosis was one of the contributing factors to Mr. K.'s respiratory impairment. His opinion is not completely documented because Dr. Rasmussen did not review the December 2003 CT scan or the interpretations by Dr. Hippensteel and Dr. Fino. However, that insufficiency does not adversely impact Dr. Rasmussen's opinion since I have previously determined the CT scan finding effectively supports, rather than negates, a finding of pneumoconiosis based on the preponderance of the chest x-rays. I have also considered that Dr. Rasmussen did not directly address whether Mr. K.'s heart issue may have contributed to his respiratory impairment. Yet, that silence is not deafening in this case because while noting the heart issue in Mr. K.'s medical history, Dr. Rasmussen's physical examination included a normal EKG and a finding of a regular heart beat.

For various reasons, the opinions of Dr. Forehand, Dr. Hippensteel, and Dr. Fino have diminished probative value on the issue of total disability due to pneumoconiosis. On the other hand, Dr. Rasmussen's documented and reasoned medical opinion is most consistent with all the objective medical evidence in the record and establishes that Mr. K.'s total disability is due to coal workers' pneumoconiosis. Accordingly, Mr. K. has proven the fourth, and final, element of entitlement under 20 C.F.R. § 718.204(c)(1).

### **Dates of Entitlement**

According to the provisions at 20 C.F.R. § 725.503 (b), in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the coal miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the Claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented." Additionally, under 20 C.F.R. § 725.309(d)(5), in the event a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the final claim became final.

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example

is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989), where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is “first able to muster evidence of total disability is not necessarily the date of onset”).

Mr. K.’s most recent prior claim was denied in June 1998. For the period between that denial and March 2003, when Mr. K. filed his first claim, I have no evidence showing that Mr. K. was totally disabled due to coal workers’ pneumoconiosis. After Mr. K. filed his present claim in March 2003, the first indication that Mr. K. had become totally disabled due to coal workers’ pneumoconiosis was Dr. Forehand’s pulmonary evaluation in May 2003. Since there is no showing Mr. K. was not totally disabled in the months between the claim filing date and Dr. Forehand’s evaluation, I find his date of entitlement is March 1, 2003.

## CONCLUSION

Based on the preponderance of the most recent exercise arterial blood gas studies, Mr. K. proven that he has become totally disabled due to a respiratory impairment, thereby establishing an element of entitlement previously adjudicated against him. Consequently, after considering all the medical evidence in the record I find that Mr. K. has coal workers’ pneumoconiosis which has caused a totally disabling pulmonary impairment. Accordingly, Mr. K.’s present claim for disability benefits under the Black Lung Benefits Act must be granted. The date of entitlement is March 1, 2003.

### **Attorney Fees**

In accordance with 20 C.F.R. §§ 725.365 and 725.366, Claimant's counsel has thirty calendar days from receipt of this decision and order to submit an application for attorney fees . With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. The other parties have fifteen calendar days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with this claim.

### **ORDER**

The claim of MR. O.K. for black lung disability benefits is **GRANTED**. The Employer, JEWELL RIDGE MINING CORP./SEA "B" MINING CO., is ordered to:

1. Pay Mr. O.K. all benefits to which he was entitled under the Act and Regulations. Benefits shall commence March 1, 2003.
2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602(a), for all interim payments made by the Black Lung Disability Trust Fund to Mr. K.
3. Deduct from the payments ordered in paragraph one, as appropriate, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph three.
4. Pay to the Secretary of Labor interest as required pursuant to 20 C.F.R. § 725.608(b).

**SO ORDERED:**

**A**

RICHARD T. STANSELL-GAMM  
Administrative Law Judge

Date Signed: October 27, 2006  
Washington, DC

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).